

## OHIC Affordability Standards: Potential 2019 Modifications and Supporting Rationale

In 2019 OHIC intends to revise the Affordability Standards, Part 4.10 of 230-RICR-20-30, to continue to improve the affordability of health care in Rhode Island through enhanced, modified and clarified standards. The purpose of this document is to inform stakeholders regarding options under consideration by OHIC, and to invite stakeholder reaction. The potential modifications identified herein were gathered during OHIC stakeholder meetings in late 2018 and early 2019 and were also identified through Affordability Standards evaluation activity.

OHIC considered many additional stakeholder recommendations made over the past several months. This document contains only those that remain under serious consideration by OHIC. Interested parties are invited to propose alternative ideas for consideration by OHIC.

Each potential modification is presented below with a brief supporting rationale and some additional detail. This document organizes modification options in the following order:

- A. Primary Investment
- B. Care Transformation
- C. Payment Reform

## A. Primary Care Investment

### 1. Continue requiring insurers to meet a primary care spending target.

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Rationale:

- According to the most recent evaluation of the Affordability Standards, stakeholders believe that the required investments towards primary care have been extremely important and have created a platform for primary care practice transformation.
- In 2017, RI insurers spent between 9.0% and 12.8% (for an average of 11.5%) of total spend on primary care<sup>1</sup>, above the required level of 10.7%
- The Milbank-funded primary care spend study (2017) did not reveal a consistent level of primary care spend as a percentage of total spend among high-quality health plans.

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Strategy Detail:

Modify the primary care spend standard to 11.0%, less the effect of removing indirect primary care spending (see Option #3 below).

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<sup>1</sup> Marie Ganim. Presentation to the Delaware Health Care Commission. October 10, 2018.

**2. Re-examine and more tightly define what constitutes primary care spending, and consider definitions being adopted in other states to promote comparisons across states.**

Rationale:	<ul style="list-style-type: none"><li>• Oregon now has a primary care spend standard<sup>2</sup>, and Delaware may be in the process of developing one.</li></ul>
Strategy Detail:	<ul style="list-style-type: none"><li>a. Define primary care spending within regulations or a new integrated policy manual, and not through guidance letters issued by OHIC.</li><li>b. Utilize a more technical definition that specifically includes and excludes certain categories of spending.</li><li>c. Investigate aligning definitions with Oregon (except for the PCP definition<sup>3</sup>) to allow for cross-state comparison.</li></ul>

**3. Eliminate the requirement to limit indirect primary care spending to <1% and require insurer support for CTC-RI administrative infrastructure and CurrentCare elsewhere in OHIC regulation.**

Rationale:	<ul style="list-style-type: none"><li>• This does not constitute true spending on primary care.</li><li>• Elimination of this requirement would streamline reporting.</li></ul>
Strategy Detail:	N/A

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<sup>2</sup> SB 934 requires health insurance carriers and Medicaid Coordinated Care Organizations to allocate at least 12 percent of their health care expenditures to primary care, by 2023.

<sup>3</sup> Oregon includes categorizes psychiatrists and OB/GYNs as primary care providers. It has produced analyses with those providers excluded, however. For detailed information on Oregon's methodology and performance data, see [www.oregon.gov/oha/HPA/ANALYTICS/Documents/SB-231-Report-2019.pdf](http://www.oregon.gov/oha/HPA/ANALYTICS/Documents/SB-231-Report-2019.pdf).

## B. Care Transformation

### 1. Remove the current PCMH target, but require continued insurer financial support of OHIC-recognized PCMHs.

Rationale:	Rhode Island has made great strides in primary care transformation. Those practices should continue to receive support, but there are a limited number of viable remaining practice candidates for transformation.
Strategy Detail:	<ol style="list-style-type: none"><li>Eliminate the care transformation requirement as currently written, which focuses on primary care practices functioning as PCMHs.</li><li>Require that practices that meet OHIC's PCMH definition continue to receive financial support, e.g., as specified in the Commissioner's 2019 Care Transformation Plan.</li></ol>

### 2. Facilitate improved integration of primary care and behavioral health services.

Rationale:	<ul style="list-style-type: none"><li>Stakeholders placed priority emphasis on this topic during the fall 2018 Care Transformation Advisory Group meetings.</li><li>Medicaid requested an OHIC requirement for insurer payment support for integrated care and SDOH work on 2-8-19.</li><li>Brown's CTC-RI BHI pilot evaluation yielded promising results.<sup>4</sup> Other research estimates that a reduction of between 5-10% of total health care costs over a period of 2-4 years for patients receiving collaborative care, though there is wide variability in study findings and quality of studies.<sup>5</sup></li></ul>
Strategy Options:	<p>Options to be developed by OHIC's Integrated Behavioral Health Work Group by June 2019, but could include:</p> <ol style="list-style-type: none"><li>elimination two co-pays for same-day primary care and behavioral health services provided in the same location;</li></ol>

<sup>4</sup> Brown M. and Coleman RE. CTC-RI Integrated Behavioral Health Pilot Program Full Evaluation Final Report. August 29, 2018.

<sup>5</sup> Melek S et al. "Potential economic impact of integrated medical-behavioral healthcare." Milliman Research Report. January 2018. See [www.milliman.com/uploadedFiles/insight/2018/Potential-Economic-Impact-Integrated-Healthcare.pdf](http://www.milliman.com/uploadedFiles/insight/2018/Potential-Economic-Impact-Integrated-Healthcare.pdf)

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- b. requiring the reimbursement of Collaborative Care codes, or other codes that are paid for by Medicare and/or Medicaid (to be fully defined by the IBH Work Group, but might also include health and behavior assessments, screening, warm hand-offs, etc.), and
  - c. credentialing requirements that support providers practicing in an integrated environment (to be fully developed by the IBH Work Group).

An additional option includes:

- d. defining the foundational elements of an integrated behavioral health practice and requiring insurers to financially support practices that achieve the foundational elements for non-reimbursed costs supportive of integrated care, e.g., warm hand-offs, health behavior groups. OHIC could look to the PCMH PRIME Certification program developed by NCQA for Massachusetts as a starting point for practice expectations.<sup>6</sup>

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<sup>6</sup> See [www.mass.gov/service-details/the-hpc-patient-centered-medical-home-pcmh-certification-program](http://www.mass.gov/service-details/the-hpc-patient-centered-medical-home-pcmh-certification-program).

### 3. Support improved and cost-effective specialist services.

Rationale:	Many specialists are independent and have been unaffected by OHIC's Affordability Standards.
Strategy Detail:	a. Require insurers to utilize reference pricing for selected high volume and high cost specialist services, (e.g., joint replacement surgery, diagnostic services). <sup>7</sup>

### 4. Create a new requirement for insurers to act to reduce primary care practice administrative burden and reduce burnout.

Rationale:	Primary care burnout is stressing the availability of primary care providers, decreasing quality of patient care and may increase medical errors. While unintended, rapid transformation, like which occurs in practices undergoing transition to PCMH, may contribute to primary care burnout. <sup>8</sup>
Strategy Detail:	a. Require insurers to act independently and collectively to reduce primary care practice administrative burden and other stressors on the quality of work. Require reports to OHIC and presentation in a public forum annually on insurer efforts.

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<sup>7</sup> Reference pricing high cost, high volume, non-emergency services has shown to be cost effective. Robinson, J et al. University of California, Berkeley. <https://bcht.berkeley.edu/sites/default/files/Reference-Pricing-Cost-Control.pdf>

<sup>8</sup> See [www.aafp.org/news/focus-on-physician-well-being/20180131burnoutstudy.html](http://www.aafp.org/news/focus-on-physician-well-being/20180131burnoutstudy.html).

## C. Payment Reform

### 1. Adopt new APM targets and Risk-Based Contract requirements

Rationale:	<ul style="list-style-type: none"><li>• OHIC should ensure a minimum percent of payments are dedicated to APMs. The current percentage target is 50%.</li><li>• The target values need updating, as they don't run past 2019.</li><li>• Risk-based contracting is an important tool driving provider performance on cost and quality.</li></ul>
Strategy Detail:	<ul style="list-style-type: none"><li>a. Set an APM adoption floor requirement that insurers must meet.</li><li>b. Articulate risk-based contracting targets and minimum downside risk standards that increase over time.</li></ul>

### 2. Regarding the aggregate APM target and the Non-FFS APM target, count both shared savings and shared losses equally so that carriers with downside risk arrangements are not penalized for them.

Rationale:	Insurers are concerned that shared losses incurred by providers in risk-based models are not considered medical payments, therefore penalizing health plans that would have met the target if those providers had earned shared savings payments. (OHIC does remove these losses from the denominator in the APM spending calculation, however.)
Strategy Options:	<ul style="list-style-type: none"><li>a. When codifying this language in the Affordability Standards, clarify a method for health plans to include shared losses within their expected non-fee-for-service target.</li><li>b. Alternatively, clarify that medical payments refers only to those dollars which are prospectively paid, as this non-FFS APM target is meant to encourage the amount of prospectively paid payments. While this would be a harder requirement for health plans to meet, it is truer to the initial intent. Also, making performance of an ACO against a shared savings or risk arrangement impact compliance creates a perverse incentive for insurers to set shared savings or risk targets that are too high or too low.</li></ul>

### 3. Add a Primary Care APM requirement.

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Rationale:	<ul style="list-style-type: none"><li>• A primary care APM can support clinical activities and functions that are indicative of well-functioning primary care practices, including care coordination, interdisciplinary-team based care, support for patient self-management and ongoing communication. It can also reduce the stress and burden created by a fee-for-service office visit volume incentive.</li><li>• Movement toward primary care APM in RI has been slow and some payers have been resistant to multi-payer and provider collaboration.</li></ul>
Strategy Detail:	<ul style="list-style-type: none"><li>a. Require insurer implementation of primary care APMs for their contracted network providers.</li><li>b. Require adoption of an OHIC developed primary care APM.</li><li>c. Set APM and Non-FFS APM targets specifically for primary care.</li></ul>

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### 4. Maintain the cap on hospital rate growth.

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Rationale:	Based on the 2018 Affordability Standards evaluation and the <i>Health Affairs</i> study by Baum et al. <sup>9</sup> , the hospital rate limits were mostly responsible for observed cost trend decreases and therefore the requirement should be maintained, if not made more aggressive, for hospital contracts.
Strategy Detail:	<ul style="list-style-type: none"><li>a. Maintain the rate growth cap.</li><li>b. Option #10 below proposes a modification to address rate disparities between hospitals in a way that encourages improved quality of care and value for consumers.</li></ul>

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<sup>9</sup> Baum et al. "Health Care Spending Slowed After Rhode Island Applied Affordability Standards to Commercial Insurers" *Health Affairs* February 2019. <https://doi.org/10.1377/hlthaff.2018.05164>



**5. Align the ACO Budget Growth Cap with the new Cost Growth Target.**

Rationale:	The OHIC ACO budget growth cap and the new Cost Growth Target are both focused on annual change in total cost of care growth, the difference being the ACO cap, based on the Consumer Price Index, is on commercial contractual cost targets and the new Cost Growth Target is focused on actual cost growth at state, insurance market, insurer and large provider levels.
Strategy Detail:	<ol style="list-style-type: none"><li>a. Change the ACO budget growth cap to equal prospective Gross State Product (PGSP) with an add-on, with a multi-year transition to lower the current cap from its current level.</li><li>b. Address possible adjustment for ACOs with comparatively low risk-adjusted PMPM spending.</li></ol>

**6. Assess community behavioral health spending**

Rationale:	OHIC has received stakeholder feedback that there are gaps in the community with respect to behavioral health services.
Strategy Detail:	<ul style="list-style-type: none"><li>a. Assess baseline spending for community behavioral health services, much as OHIC previously did for primary care.</li><li>b. Direct insurers to make investments if upon further quantitative and qualitative analysis the Commissioner finds it to be necessary.</li></ul>

**7. Clarify the requirement for hospitals to use units-of-service payments.**

Rationale:	Units-of-service payments are not used in all inpatient and outpatient cases (e.g., inpatient psychiatry, emergency department).
Strategy Detail:	N/A

**8. Move the administrative requirements from the Affordability Standards.**

Rationale:	The hospital contract administrative requirements may be important but are not a key focus of the Affordability Standards.
Strategy Detail:	<ul style="list-style-type: none"><li>a. Move administrative simplification requirements outside of the Affordability Standards and to the administrative simplification requirements section of Part 4.</li></ul>

**9. Address disparity in commercial hospital rates.**

Rationale:	As the hospital rate caps continue, the variation in hospital rates will continue to get wider in that the highest reimbursed hospitals will continue see higher rate increases than the lowest reimbursed hospitals in absolute dollar terms. This has been a concern of some community hospitals in Rhode Island.
Strategy Detail:	<ol style="list-style-type: none"><li>Variable application of rate growth caps, e.g., standard caps for “higher-priced hospitals”, and earnable higher caps for “lower-priced hospitals” vis a vis the state median.</li><li>Tie the rate cap differential to quality performance, such that “lower-priced” hospitals must earn any available add-on above the standard rate cap.</li><li>OHIC shall define the quality measures and targets necessary to realize the higher rate cap.</li><li>Publish annual reports on hospital price variation to increase attention to the topic.</li></ol>

**10. Require insurer acceptance of multi-payer provider-generated quality measurement information in value-based provider contracts when requested by providers.**

Rationale:	Providers incur additional costs when they are required to generate separate payer-specific quality measurement data for commonly used measures. These costs do not add value, decrease the statistical strength of the measurements due to reduced denominator size, and don't recognize that clinicians do not deliver care differently based on a patient's insurer
Strategy Detail:	<ul style="list-style-type: none"><li>a. For those ACOs and providers that wish to use an aggregated calculation of performance across all commercial (insurer and self-insured) patients for performance measures used in ACO and provider contracts and which rely upon clinical data for their calculation, the insurer is obligated to accept those measurements.</li><li>b. Insurers may elect to impose reasonable audit requirements upon the ACO or provider to ensure validity of reported data.</li></ul>